Senate Study Bill 1161 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE ON HUMAN RESOURCES BILL BY CHAIRPERSON SEGEBART)

A BILL FOR

An Act relating to prior authorization by a utilization review entity for coverage of health care services and including applicability provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **514F.7 Prior authorization.**

1. *Definitions.* For purposes of this section:

a. (1) *"Adverse determination"* means a determination by a utilization review entity that an admission, availability of care, continued stay, or other health care service, other than a dental care service, that is a covered benefit has been reviewed and, based upon the information provided, does not meet the utilization review entity's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

(2) For the purposes of denial of a dental care service, *"adverse determination"* means a determination by a utilization review entity that a dental care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the utilization review entity's requirements for medical necessity, and the requested service or payment for the service is therefore denied, reduced, or terminated in whole or in part.

(3) *"Adverse determination"* does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.

b. *"Authorization"* means a determination by a utilization review entity that a requested health care service has been reviewed and, based upon the information provided, meets the utilization review entity's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and that payment will be made for the requested service.

c. *"Clinical review criteria"* means the written policies, screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by a utilization review entity to determine the necessity and appropriateness of health care

services.

d. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan. *"Covered person"* includes a covered person's legally authorized representative.

e. "Dental care services" means diagnostic, preventive, maintenance, and therapeutic dental care that is provided in accordance with chapter 153.

f. "Emergency health care services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

g. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

h. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

i. "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

j. "Health care professional" means a physician or other health care practitioner licensed, accredited, registered, or certified to perform specified health care services consistent with state law.

k. *"Health care provider"* or *"provider"* means a health care professional or a facility.

l. *"Health care services"* means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease provided by a health care provider. *"Health care services"* includes dental care services and the provision of pharmaceutical products or services or durable medical equipment.

m. *"Health carrier"* means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. *"Health carrier"* includes, for purposes of this section, an organized delivery system.

n. *"Medically necessary health care services"* means health care services and supplies that a prudent health care provider would provide to a covered person for the purpose of preventing, diagnosing, or treating a health condition, illness, injury, or disease, or the symptoms of an illness, injury, or disease in a manner that is all of the following:

(1) In accordance with generally accepted standards of medical practice.

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(3) Not primarily for the economic benefit of the health benefit plan or health care provider or for the convenience of the covered person or the health care provider.

o. *"Organized delivery system"* means an entity system authorized under 1993 Iowa Acts, ch. 158, and licensed by the director of public health, and performing utilization review.

p. *"Prior authorization"* means the process by which a

utilization review entity determines the medical necessity or medical appropriateness of otherwise covered health care services prior to the rendering of such health care services including but not limited to preadmission review, pretreatment review, utilization, and case management. *"Prior authorization"* includes a utilization review entity's requirement that a covered person or health care provider notify the utilization review entity prior to receiving or providing a health care service.

q. "Urgent health care service" means a health care service subject to prior authorization prescribed for a covered person, for which the time periods for making a nonexpedited prior authorization, could, in the opinion of a health care professional with knowledge of the covered person's medical condition, do either of the following:

(1) Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

(2) Subject the covered person to severe pain that cannot be adequately managed without the health care service that is the subject of prior authorization.

r. (1) *"Utilization review entity"* means an individual or entity that performs prior authorization for one or more of the following entities:

(a) An employer with employees in Iowa who are covered under a health benefit plan.

(b) A health carrier.

(c) Any individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health care services.

(2) *"Utilization review entity"* includes a health carrier that performs prior authorization for its own health benefit plans.

2. *Prior authorization requirements and restrictions —— disclosure.*

a. A utilization review entity shall make any current prior authorization requirements or restrictions, including clinical review criteria, readily accessible on the entity's internet site to covered persons, health care providers, and the general public. The restrictions and requirements shall be described in detail but in easily understandable language.

b. A utilization review entity shall not implement a new or amended prior authorization requirement or restriction until the utilization review entity has done both of the following:

(1) Updated the utilization review entity's internet site to reflect the new or amended requirement or restriction.

(2) Provided written notice of the new or amended requirement or restriction not less than sixty calendar days before the new or amended requirement or restriction is implemented to health care providers contracted to provide health care services pursuant to a health benefit plan to which the prior authorization requirement or restriction applies.

c. A utilization review entity shall make statistics available on the entity's internet site in a readily accessible format that indicate how prior authorization is applied on the basis of each of the following:

(1) Specialty of the health professional.

(2) Type of health care service requested.

(3) The clinical indication offered for requesting a health care service.

(4) Reason for denial of prior authorization.

3. *Utilization review entity's obligations with respect to prior authorization.*

a. If a utilization review entity requires prior authorization for coverage of a nonurgent health care service, the entity shall either give prior authorization covering the nonurgent health care service or make an adverse determination denying coverage of the nonurgent health care service within five calendar days of obtaining all necessary information to give authorization or make an adverse determination. A

contractual timeline may vary from this standard but in no event shall the timeline for giving authorization or making an adverse determination for coverage of a nonurgent health care service exceed five calendar days.

b. If a utilization review entity requires prior authorization for coverage of an urgent health care service, the entity shall either give prior authorization covering the urgent health care service or make an adverse determination denying coverage of the urgent health care service and notify the covered person and the covered person's health care provider of that authorization or denial within seventy-two hours of obtaining all necessary information to give authorization or make an adverse determination. A contractual timeline may vary from this standard but in no event shall the timeline for giving authorization or making an adverse determination for coverage of an urgent health care service exceed seventy-two hours.

c. For purposes of this subsection, "*necessary information*" includes the results of a face-to-face clinical evaluation or second opinion that may be required.

4. *Utilization review entity's obligations with respect to coverage of emergency health care services.*

a. A utilization review entity shall not require prior authorization for emergency transportation to a hospital or for the provision of emergency health care services.

b. A utilization review entity shall allow a covered person and the covered person's health care provider a minimum of twenty-four hours following an emergency hospital admission or the provision of emergency health care services to the covered person, to notify the utilization review entity of the emergency hospital admission or provision of emergency health care services. If the emergency hospital admission or provision of emergency health care services occurs on a holiday or weekend, the utilization review entity shall not require such notification until the next business day after the holiday

or weekend.

c. A utilization review entity shall authorize coverage of emergency health care services necessary to screen and stabilize a covered person. If a health care provider certifies in writing to a utilization review entity within seventy-two hours of a covered person's admission to a hospital that the covered person's condition required emergency health care services, that certification shall create a presumption that the emergency health care services were medically necessary and such presumption may be rebutted only if the utilization review entity can establish, by clear and convincing evidence, that the emergency health care services provided were not medically necessary.

d. A determination of the medical necessity or appropriateness of emergency health care services provided to a covered person shall not be based on whether or not those services were provided by a health care provider under contract to provide health care services pursuant to a health benefit plan. Requirements or restrictions on coverage of emergency health care services provided by health care providers not under contract to provide services pursuant to a health benefit plan shall not be greater than requirements or restrictions that apply when those services are provided by a health care provider under contract to provide such services pursuant to the health benefit plan.

e. If a covered person receives emergency health care services that require immediate postevaluation or poststabilization health care services, a utilization review entity shall give prior authorization or make an adverse determination within sixty minutes of receiving a request for prior authorization. If the utilization review entity does not give authorization for or deny coverage of the postevaluation or poststabilization health care services within sixty minutes of receiving the request, coverage of such services shall be deemed to be authorized.

5. *Retrospective denial.* A utilization review entity shall not revoke, limit, condition, or restrict prior authorization after the date on which a health care provider provides the health care services for which authorization was received. Any language that attempts to disclaim payment for health care services that have received prior authorization shall be null and void.

6. *Duration.* A prior authorization shall be valid for not less than one year from the date a health care provider receives the prior authorization.

7. *Expedited renewal.* A utilization review entity shall develop an expedited process for the renewal of an existing prior authorization including a certification that the factors constituting medical necessity or medical appropriateness of the health care services for which renewal of prior authorization is sought remain unchanged from the factors that were considered before issuance of the original prior authorization.

8. *Administrative services fees.*

a. A utilization review entity shall establish an administrative services fee schedule for prior authorization determinations, consistent with the federal Medicare resource-based relative value scale methodology used to reimburse health care professionals for medical reports. The fee schedule shall be utilized by the utilization review entity to determine the amount of payments to health care professionals who complete administrative services required by the utilization review entity as a condition of giving prior authorization or making an adverse determination.

b. For the purpose of this subsection, *"administrative services"* includes but is not limited to peer-to-peer clinical consultations or second opinions, and completion of certification documentation. *"Administrative services"* does not include those services rendered by a health care professional in the provision of health care services to a covered person.

9. *Failure to comply with this section.* Upon the failure of a utilization review entity to comply with deadlines or other requirements specified in this section, any health care services subject to prior authorization shall be deemed to be automatically preauthorized.

10. *Severability.* If any provision of this section or the application of this section to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the section which can be given effect without the invalid provision or application.

Sec. 2. APPLICABILITY. This Act applies to a health benefit plan that is delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2018.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to prior authorization of health care services by a utilization review entity and includes applicability provisions.

The bill provides that a utilization review entity that requires prior authorization for coverage of health care services must make its prior authorization requirements or restrictions readily accessible on its internet site. The entity cannot implement new or amended prior authorization requirements or restrictions until its internet site has been updated and health care providers contracted to provide the health care services to which the requirements or restrictions apply have been given not less than 60 calendar days' written notice of the changes. A utilization review entity must make specified statistics about application of prior authorization available on its internet site.

If prior authorization is required for coverage of a nonurgent health care service, a utilization review entity must either give prior authorization to cover the service or make an adverse determination denying such coverage within

five calendar days of obtaining all necessary information. If prior authorization is required for coverage of an urgent health care service, a utilization review entity must give prior authorization to cover the service or make an adverse determination denying such coverage within 72 hours of obtaining all necessary information. For purposes of the bill, "necessary information" includes the results of a face-to-face clinical evaluation or second opinion that may be required.

A utilization review entity cannot require prior authorization for emergency transportation to a hospital or for the provision of emergency health care services. A utilization review entity must allow a person covered by a health benefit plan and the person's health care provider a minimum of 24 hours to notify the entity following an emergency hospital admission or the provision of emergency health care services, on the next business day if the admission or provision of services occurs on a holiday or weekend.

A utilization review entity shall authorize coverage of emergency health care services necessary to screen and stabilize a covered person. If a health care provider certifies in writing to a utilization review entity within 72 hours of a covered person's admission to a hospital that the covered person's condition required emergency health care services, that certification shall create a presumption that the emergency health care services were medically necessary and such presumption may be rebutted only if the utilization review entity can establish, by clear and convincing evidence, that the emergency health care services provided were not medically necessary.

A determination of the medical necessity or appropriateness of emergency health care services provided to a covered person cannot be based on whether or not those services were provided by a health care provider under contract to provide health care services pursuant to a health benefit plan. Requirements or restrictions on coverage of emergency health care services

provided by health care providers not under contract to provide services pursuant to a health benefit plan cannot be greater than restrictions or requirements that apply when those services are provided by a health care provider under contract to provide such services pursuant to the health benefit plan.

If a covered person receives emergency health care services that require immediate postevaluation or poststabilization health care services, a utilization review entity shall give authorization or make an adverse determination within 60 minutes of receiving a request for prior authorization, and if the entity does not authorize or deny coverage of the health care services within that time, coverage of such services is deemed to be authorized.

A utilization review entity cannot revoke, limit, condition, or restrict a prior authorization after the date on which a health care provider provides the health care services for which authorization was received. Any language that attempts to disclaim payment for health care services that have received prior authorization is null and void.

A prior authorization is valid for not less than one year from the date a health care provider receives the prior authorization. A utilization review entity shall develop an expedited process for the renewal of an existing prior authorization including a certification that the factors constituting medical necessity or medical appropriateness of the health care services for which the renewal is sought remain unchanged from the factors that were considered before issuance of the original prior authorization.

A utilization review entity is required to establish an administrative services fee schedule for prior authorization determinations, consistent with the federal Medicare resource-based relative value scale methodology used to reimburse health care professionals for medical reports. The fee schedule shall be utilized by the utilization review entity to determine the amount of payments to health care

professionals who complete administrative services required by the utilization review entity as a condition of making a prior authorization determination. "Administrative services" includes but is not limited to peer-to-peer clinical consultations or second opinions, and completion of certification documentation. "Administrative services" does not include those services rendered by a health care professional in the provision of health care services to a covered person.

If a utilization review entity fails to comply with deadlines or other requirements of the bill, any health care services subject to prior authorization are deemed to be automatically preauthorized.

The provisions of the bill are severable and if any provision or application of a provision is held invalid, the other provisions or applications can be given effect without the invalid provision or application.

The provisions of the bill are applicable to a health benefit plan that is delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2018.